STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155343	B. WING			03/01/2011	
NAME OF F	PROVIDER OR SUPPLIER	<del>"</del>	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
				0770 N			
LIFE CA	RE CENTER OF LA	GRANGE		LAGRA	NGE, IN46761		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	`				CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	
PREFIX TAG  K0000	A Life Safety and State Lice conducted by Department of with 42 CFR 4 Survey Date: 03/01/11  Facility Numb Provider Num AIM Number: Surveyor: Rice Safety Code (In Safety Code (	oer: 000235 ber: 155343 100267740 chard D. Schade, Life pecialist afety Code survey, ter of LaGrange was ompliance with for Participation in dicaid, 42 CFR 0(a), Life Safety from 000 edition of the Protection NFPA) 101, Life LSC), Chapter 19, th Care Occupancies	Koo	PREFIX TAG  000		of tive blan f rt of	DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6SN221

Facility ID:

000235

If continuation sheet

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155343		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMI	(X3) DATE SURVEY  COMPLETED  03/01/2011		
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LAGRANGE			STREET ADDRESS, CITY, STATE, ZIP CODE  0770 N 075 E  LAGRANGE, IN46761				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	construction a sprinklered. The alarm system in the corridors capacity of 10 and the time.  Quality Review by Safety Code Specia 03/07/11.  The facility we compliance we aforementione.	be of Type V (111)  nd was fully The facility has a fire with smoke detection as and spaces open to The facility has a 0 and had a census of of this survey.  Robert Booher, REHS, Life list-Medical Surveyor on  as found not in ith the					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155343	A. BUILDING			03/01/2011	
		1000+0	B. WIN		ADDRESS CITY STATE ZID CODE	00/01/2011	
NAME OF F	PROVIDER OR SUPPLIER			0770 N	ADDRESS, CITY, STATE, ZIP CODE		
LIFE CAF	RE CENTER OF LA	GRANGE			NGE, IN46761		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE	
K0018	Based on obse		K00		K 0018	03/31/2011	
SS=E		facility failed to			Corrective action accomplishe		
00 L	· ·	ore than 150 corridor			for residents affected by the alleged deficient practice: On		
		atch into the door			3/1/11, the maintenance direct	l l	
		provided with a			fixed the door latch on room 20 How the facility will identify oth	l l	
		erts at least 5 pounds			residents potentially affected b	y	
		keep the door tightly			the same deficient practice: The maintenance director or design		
	_	eficient practice			will conduct a weekly audit to		
		ecupants in the south			ensure all doors latch properly What measures were put into		
		smoke compartment			place or systemic changes ma	de	
	including staff	_			to ensure that the alleged		
	residents.	, visitois una			deficient practice does not rec The maintenance director will		
	residents.				to his facility rounds checklist t		
	Findings inclu	de·			ensure that all doors latch properly.		
	1 mamgs mera	uc.			How corrective actions will be		
	Based on obse	rvation on 03/01/11			monitored to ensure the allege deficient practice will not recur		
		with the maintenance			The maintenance director or	•	
		corridor door to			designee will follow the above		
	resident room				audits for three months and provide the Executive Director		
		a latch which latched			with the results of those audits		
		rame, or a device to			monthly. The Executive Direct will present data from the audi	l l	
		t five pounds of			at the monthly QA/QI meetings	S.	
	•	ep the door closed.			Utilizing a threshold of 100%, a the discretion of the QI	at	
	The maintenar	-			committee, audits will then be		
	acknowledged	-			adapted to accommodate the need to increase/decrease the		
	_	ne door did not			number of audits and frequence		
		when pressure was			of audits.		
	applied.	when pressure was					
	аррпса.						

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
155343			B. WING			03/01/2	011
NAME OF I	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE	•	
	RE CENTER OF LA				075 E NGE, IN46761		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	3.1-19(b)						

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  ND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155343		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  D. WING			(X3) DATE SURVEY  COMPLETED  03/01/2011	
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LAGRANGE			B. WING 05/01/2011  STREET ADDRESS, CITY, STATE, ZIP CODE  0770 N 075 E  LAGRANGE, IN46761				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE (	(X5) COMPLETION DATE
K0143 SS=E	Based on obserview, the ensure 1 of 11 areas was provindicating oxy occurring. The could affect revisitors in and storage and transferring of occurring. Based on observation of the factor of the fac	rvation and facility failed to iquid oxygen storage rided with signage gen transferring is is deficient practice sidents, staff and near the oxygen ansfilling room.  de:  rvation with the upervisor during a fility at 10:25 a.m. on facility's oxygen ansfilling room from the kitchen was with a sign indicating foxygen was sed on interview at servation, the	K01	43	K 0143 Corrective action accomplisher for residents affected by the alleged deficient practice: On 3/25/11, the maintenance directored a sign which states, "OXYGEN TRANSFER STAT OPEN/IN USE." How the facility will identify offersidents potentially affected to the same deficient practice: The maintenance director or design will monitor weekly to ensure to oxygen room has proper signary. What measures were put into place or systemic changes mate to ensure that the alleged deficient practice does not recomply that the maintenance director will to his facility rounds checklist monitoring of proper oxygen resignage. How corrective actions will be monitored to ensure the alleged deficient practice will not recurred to ensure the alleged deficient practice will not recurred to ensure the alleged deficient practice will not recurred to ensure the alleged deficient practice will not recurred to ensure the alleged deficient practice will not recurred to the executive Director with the results of those audits monthly. The Executive Director will present data from the audit at the monthly QA/QI meeting Utilizing a threshold of 100%, the discretion of the QI committee, audits will then be adapted to accommodate the need to increase/decrease the number of audits and frequence of audits.	ctor ION ner by he nee the age. ade sur: add the boom ed r:	03/31/2011

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155343		A. BUILI	DING	NSTRUCTION	(X3) DATE COMPL 03/01/2	ETED	
100040			B. WING		DDDEGG GITTL OTT TO CON-	03/01/2	011
NAME OF P	ROVIDER OR SUPPLIER			0770 N	ADDRESS, CITY, STATE, ZIP CODE		
	RE CENTER OF LA			LAGRA	NGE, IN46761		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	l r	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	facility's oxyg						
		om was provided.					
	transming roc	on was provided.					
	2 1 10/1-)						
	3.1-19(b)						

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
THEFTERN	or condition	155343	A. BUILDING			03/01/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			0770 N			
LIFE CAI	RE CENTER OF LA	GRANGE			ANGE, IN46761	·	
(X4) ID		FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
K0144		rvation, record	K01		K 0144	03/31/2011	
SS=F		erview; the facility			Corrective action accomplishe for residents affected by the	d	
		e 1 of 1 emergency			alleged deficient practice: On		
		s equipped with			3/11/11, the maintenance dire contacted H & G Services to	ctor	
	~	l stops. LSC 7.9.2.3			install an emergency shut swit	ch	
		gency generators			on the emergency generator.		
		er to emergency			How the facility will identify oth residents potentially affected by		
		ns shall be installed,			the same deficient practice: The	ne	
	tested and mai				maintenance director or design will conduct an audit on the no		
	accordance wi	th NFPA 110.			load test and monthly load tes	t	
	Standard for E	· ·			weekly and will document in the preventative maintenance logs		
		r Systems. NFPA			What measures were put into	). 	
	_	ion, 3-5.5.6 requires			place or systemic changes ma	de	
	*	lations shall have a			to ensure that the alleged deficient practice does not rec	ur:	
	remote manual	l stop station of a			The maintenance director will		
		a break-glass station			to his facility rounds checklist the ensure the generator is	10	
		nere on the premises			functioning per regulation.		
		ne mover is located			How corrective actions will be monitored to ensure the allege	ed l	
	_	ilding. NFPA 37,			deficient practice will not recur		
		ne Installation and			The maintenance director or designee will follow the above		
	Use of Station	ary Combustion			audits for three months and		
		as Turbines, 1998			provide the Executive Director with the results of those audits		
	Edition, at 8-2	.2(c) requires engines			monthly. The Executive Direct		
		ower or more have			will present data from the audi at the monthly QA/QI meetings		
	provision for	shutting down the			Utilizing a threshold of 100%,		
	engine at the e	ngine and from a			the discretion of the QI		
	remote location	n. This deficient			committee, audits will then be adapted to accommodate the		
	practice could	affect all residents,			need to increase/decrease the		
					number of audits and frequent of audits.	cy	
					J. Sadito.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6SN221

Facility ID:

000235

If continuation sheet

Page 7 of 9

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155343		(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/01/2011	
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LAGRANGE			0770 N	ADDRESS, CITY, STATE, ZIP COD 075 E NGE, IN46761	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	staff and visito emergency.	ors in the event of an				
	Findings inclu	de:				
	Energency.  Based on review of the Generator Maintenance records on 02/28/11 at 3:40 p.m. with the maintenance supervisor, there was no documentation available which indicated the amount of horsepower the generator provided. Based on observation of generator equipment on 03/01/11 at 10:45 a.m. during a tour of the facility with the maintenance supervisor, no evidence of a remote shut off device was found for the generator, furthermore, the maintenance supervisor indicated he was not sure if the generator was 100 horsepower or more and it was installed prior to 2003. The maintenance supervisor thought there was a remote shut off device for the generator and tried to test a switch, but it failed to stop the generator from running.					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155343		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED  B. WING 03/01/2011			
NAME OF F	PROVIDER OR SUPPLIER		STREET .	ADDRESS, CITY, STATE, ZIP CODE	1
LIFE CAI	RE CENTER OF LA	GRANGE	0770 N LAGRA	1075 E ANGE, IN46761	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)				